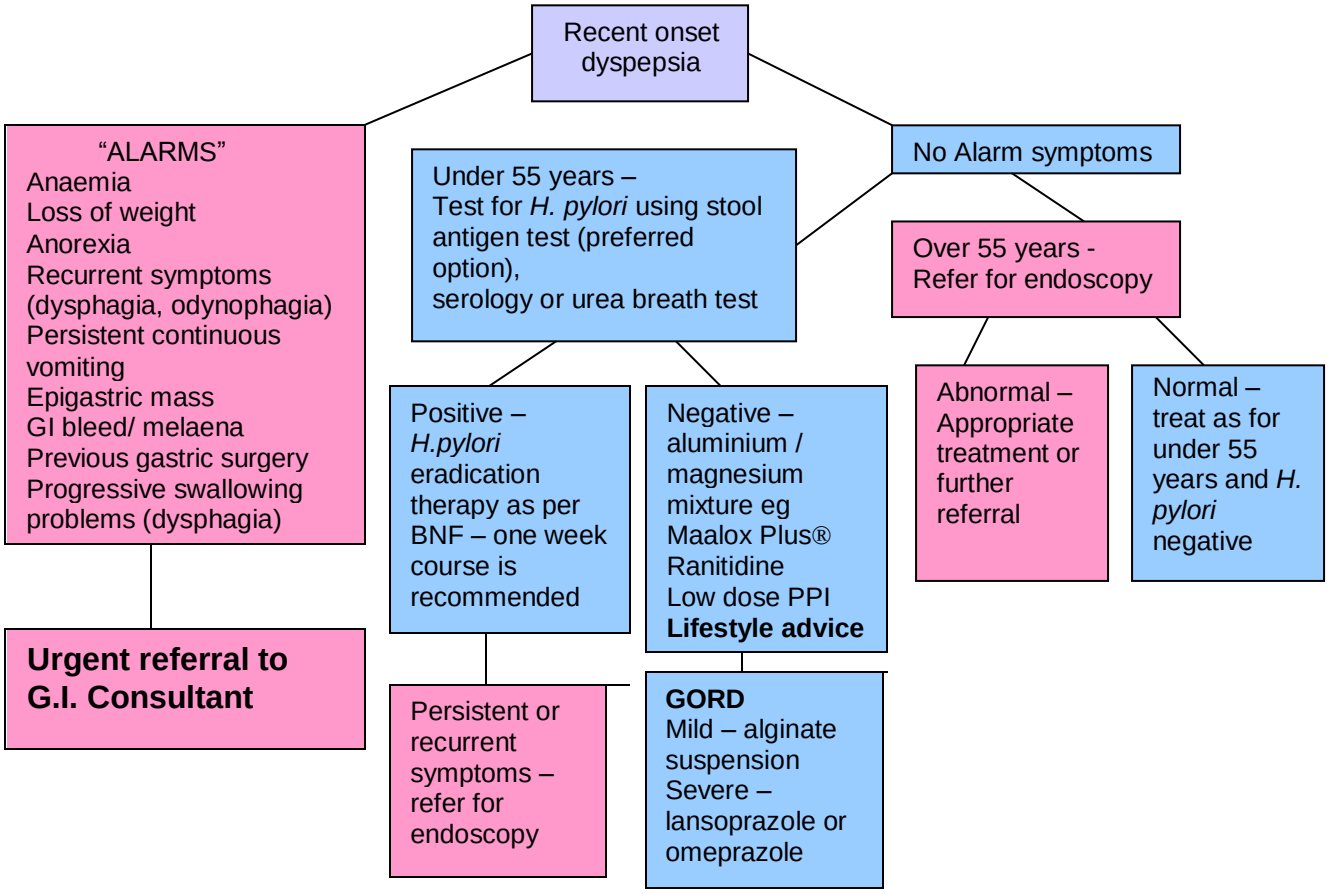
Dyspepsia Guidelines



Additional Information on PPIs

- PPIs are over-prescribed.
- Many patients can be adequately treated with a cost effective alginate such as Peptac
- Patients should have a documented and appropriate indication for receiving a PPI
- PPIs suppress gastric acid and cause bacterial overgrowth eg with *C difficile*
- Long-term use of PPIs can cause temporary problems of rebound hyperacidity on withdrawal
- Increased risk of hip fracture with long-term PPI use
- If NSAID treatment is essential and the patient has an ulcer, prescribe the treatment dose of omeprazole or lansoprazole (cost effective options)
- If NSAID treatment must continue and the patient has non-ulcer dyspepsia, use a maintenance PPI dose

When Not to Refer for Endoscopy

- Aged under 55 years and no alarm signs
- Not yet tested for *H. pylori* and treated, if necessary
- Recent normal endoscopy result but persistent symptoms
- Long established dyspepsia that has not become worse over a period of time

NB

- Most GI ulcers are strongly associated with *H. pylori* infection
- 30% of endoscopy results are normal
- 2% diagnose oesophago/gastric cancer
- Endoscopy is expensive

Wirral Clinical Commissioning Group

Wirral University Teaching Hospital NHS
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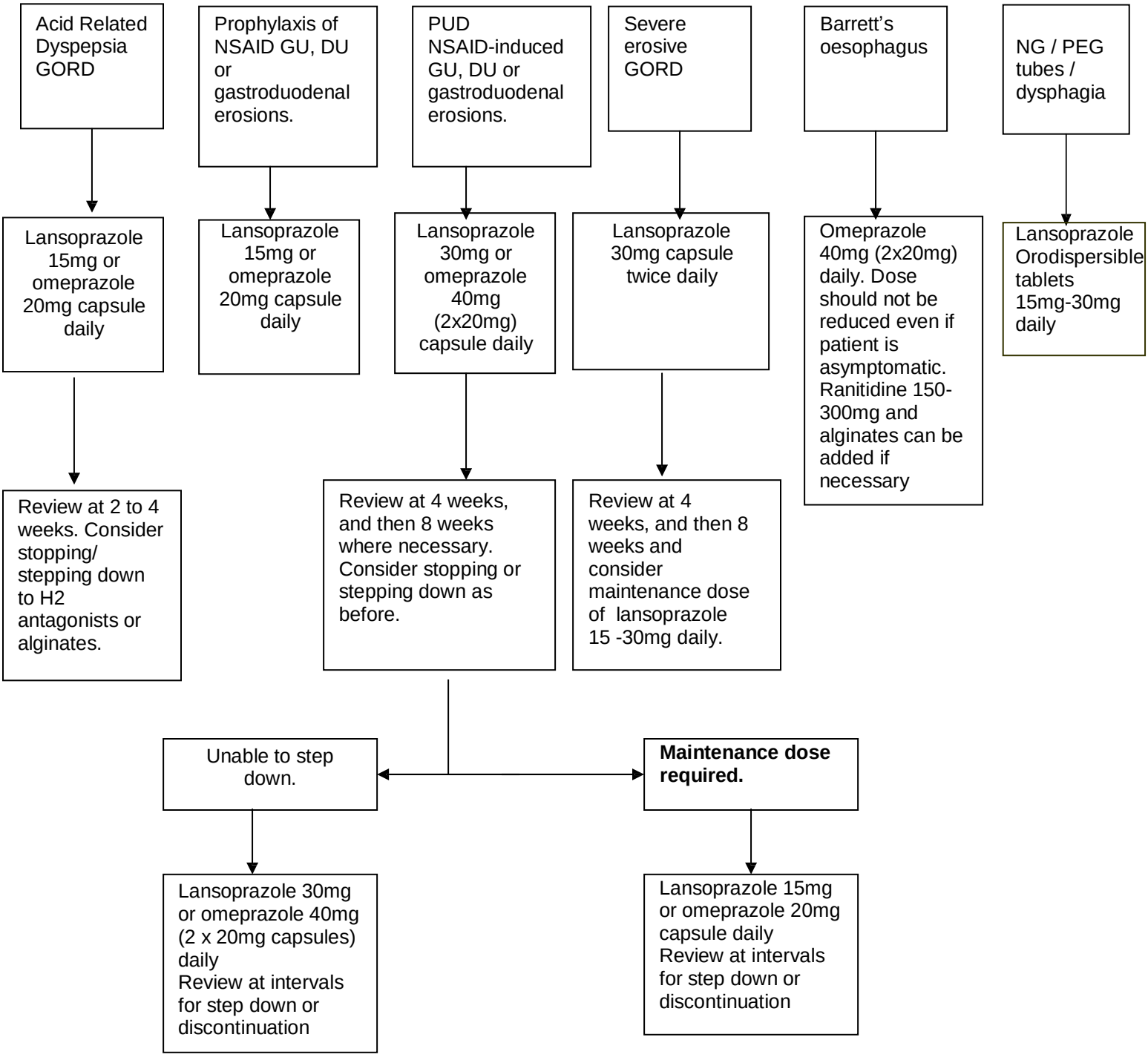
CHOICE OF PROTON PUMP INHIBITOR (PPI)



Appropriate lifestyle modifications such as diet, alcohol intake and smoking should always be encouraged

Note: Lansoprazole orodispersible tablets should be placed on the tongue, allowed to disperse and then swallowed, or dispersed in water and then swallowed / administered via a feeding tube.

Additional Information

Treatment of Gastric and Duodenal Ulcers
PPIs are effective short term treatments for gastric and duodenal ulcers
H. pylori causes 80% of gastric ulcers and 95% of duodenal ulcers.
NSAIDs are responsible for most of the remainder of peptic ulcers
All patients should be tested for *H.pylori*

***H. pylori* negative:** Ranitidine or PPI therapy for 1-2 months and stop the NSAID if possible. Consider long term therapy with a PPI if the NSAID cannot be stopped.

***H. pylori* positive:** Eradication therapy as recommended in the BNF for one week, followed by a further three weeks of PPI therapy if the ulcer is large or complicated by haemorrhage or perforation. Offer *H pylori* retesting for *H pylori* 6-8 weeks after beginning treatment depending on the size of the lesion. See box below if symptoms persist.

PPI maintenance is only needed in patients with persistent H.pylori infection or those at risk of serious complications while receiving NSAIDs

GI referral is advised if the ulcer is not associated with *H.pylori* or an NSAID

Follow up: Repeat endoscopy with biopsies is essential until gastric ulcers are completely healed because of the small risk that cancer is present. Consider surgery if ulcer remains unhealed for six months.
Repeat endoscopy is not needed for duodenal ulcers but a follow up test for *H pylori* should be performed one month or longer after eradication therapy if symptoms persist or recur.

NSAIDs and COX-2 Inhibitor therapy
If possible, these should be avoided in the following patients

-History of an ulcer –
-Dyspepsia
-Those receiving low-dose aspirin
-The elderly – patients over 70 years on an NSAID are at **significant** risk of peptic ulcer disease

High risk patients and those with a proven ulcer should be co-prescribed a PPI if an NSAID is considered essential and should also be tested and treated, if necessary, for *H. pylori*

H. pylori
If patient tested positive and symptoms persist after triple therapy, re-test 6-8 weeks after previous eradication therapy and prescribe an alternative eradication therapy. If the retest is positive and the ulcer is still present after 6-8 weeks, refer for endoscopy. Serum antigen testing is not appropriate for a re-test (stool antigen test or carbon-13 urea breath test is preferred) and patient must have been off PPIs for at least 2 weeks prior to either test or it is not valid.

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Updated by Helen Dingle, Prescribing Adviser, NW CSU Medicines Management Team
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References
NICE Clinical Guideline CG186 September 2014 Dyspepsia and gastro-oesophageal reflux disease: Investigation and management of dyspepsia, symptoms suggestive of gastro-oesophageal reflux disease, or both https://www.nice.org.uk/guidance/cg184
British National Formulary https://www.medicinescomplete.com/mc/bnf/current/ accessed November 2014